Cultural Diversity and Health Care

By

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with thanks to
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Cultural Diversity and Health Care

I. Introduction

Cultural Diversity (even in Utah)

Salt Lake Tribune - *9/28/97*

How many primary languages spoken by Salt Lake County students in public schools?

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I. Introduction

Cultural Diversity (even in Utah)

Salt Lake Tribune - *9/28/97*

67 Major Languages spoken as the primary language by Salt Lake County students in public schools!

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II. What is Culture?

We All Have It!

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II. What is Culture?

We All Have It!

Obvious Manifestations:

- Religion
- Ethnicity (Race?)
- National Origin (language)
- Gender

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II. What is Culture?

We All Have It!

Less Obvious Manifestations:

- Age
- Education
- Economic status
- Mobility (including handicaps)

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II. What is Culture?

<u>Definition</u>: the sum total of the way of living; includes values, beliefs, standards, language, thinking patterns, behavioral norms, communication styles, etc. Guides decisions and actions of a group through time.

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III. Expression of Culture in Health Care

A. Health Belief Systems

1. Define and categorize health and illness.
2. Offer explanatory models for illness.

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III. Expression of Culture in Health Care

A. Health Belief Systems

3. Based upon theories of the relationship between cause and the nature of illness and treatments.

4. Defines the specific “scope” of practice for healers.

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III. Expression of Culture in Health Care

B. The "Culture" of Western Medicine

Erika Brady, Ph.D., Programs in Folk Studies
Western Kentucky University

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III. Expression of Culture in Health Care

B. The "Culture" of Western Medicine

1. Meliorism - make it better
2. Dominance over nature - take control
3. Activism - do something
4. Timeliness - sooner than later
5. Therapeutic aggressiveness - stronger=better
6. Future orientation - plan, newer=better
7. Standardization - treat similar the same

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B. The "Culture" of Western Medicine

	"Ours"	"Others"
A.	Make It Better	Accept With Grace
B.	Control Over Nature	Balance/Harmony with Nature
C.	Do Something	Wait and See
D.	Intervene Now	Cautious Deliberation

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B. The "Culture" of Western Medicine

	"Ours"	"Others"
E.	Strong Measures	Gentle Approach
F.	Plan Ahead	Take Life as it Comes
	Recent is Best	"Time Honored"
G.	Standardize	Individualize
	Treat Everyone the Same	Recognize Differences

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IV. Cultural Competence

A. Definition:

A set of congruent *behaviors, practices, attitudes and policies* that come together in a system or agency or among professionals, enabling effective work to be done in cross-cultural situations.

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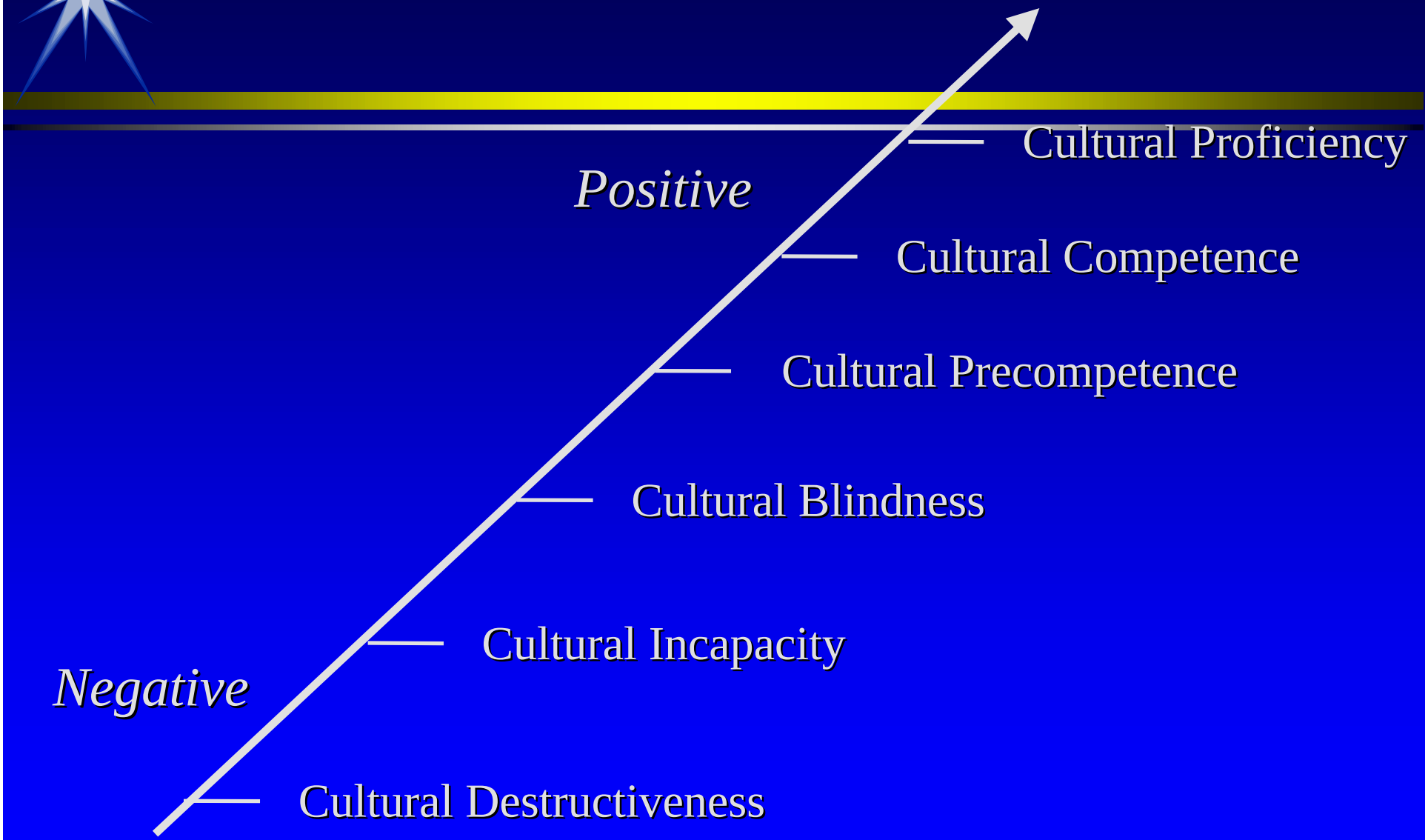
IV. Cultural Competence

B. The Cultural Competence Continuum

1. Where Am I Now?
2. Where Could I Be?

The Cultural Competence Continuum



Source: Sockalingum adapted from Hayes, M. Cultural Competence Continuum, 1993 and Terry Cross, Cultural Competency Continuum.

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IV. Cultural Competence

B. The Cultural Competence Continuum

Cultural Destructiveness: *forced assimilation, subjugation, rights and privileges for dominant groups only.*

Cultural Incapacity: *racism, maintain stereotypes, unfair hiring practices.*

Cultural Blindness: *differences ignored, "treat everyone the same," only meet needs of dominant groups.*

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IV. Cultural Competence

B. The Cultural Competence Continuum

Cultural Precompetence: *explore cultural issues, are committed, assess needs of organization and individuals.*

Cultural Competence: *recognize individual and cultural differences, seek advice from diverse groups, hire culturally unbiased staff.*

Cultural Proficiency: *implement changes to improve services based upon cultural needs, do research and teach.*

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IV. Cultural Competence

C. Acquiring Cultural Competence

1. Starts with Awareness,
2. Grows with Knowledge,
3. Enhanced with specific Skills,
4. Polished through Cross-Cultural Encounters.

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IV. Cultural Competence

D. Dealing with Cultural Diversity

The Explanatory Model - *Arthur Kleinman, Ph.D.*

1. What do you call your problem?
2. What do you think caused your problem?
3. Why do you think it started when it did?
4. What does your sickness do to you? How does it work?

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IV. Cultural Competence

D. Dealing with Cultural Diversity

The Explanatory Model - *Arthur Kleinman, Ph.D.*

5. How severe is it? How long do you think you will have it?
6. What do you fear most about your illness?
7. What are the chief problems your sickness has caused you?

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IV. Cultural Competence

D. Dealing with Cultural Diversity

The Explanatory Model - *Arthur Kleinman, Ph.D.*

8. Anyone else with the same problem?
9. What have you done so far to treat your illness? What treatments do you think you should receive? What important results do you hope to receive from the treatment?

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IV. Cultural Competence

D. Dealing with Cultural Diversity

The Explanatory Model - *Arthur Kleinman, Ph.D.*

10. Who else can help you?

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IV. Cultural Competence

D. Dealing with Cultural Diversity

The LEARN Model - *Berlin and Fowkes*

LISTEN to the patient's perception of the problem.
EXPLAIN your perception of the problem.
ACKNOWLEDGE and discuss differences/similarities.
RECOMMEND treatment.
NEGOTIATE treatment.

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V. Working with Interpreters

Putsch III RW. Cross-cultural communication: The special case of interpreters in health care. JAMA 1985;254(23):3344-48.

A. Qualifications:

Bilingual, Bicultural, understands English medical vocabulary

Comfort in the medical setting, understands significance of the health problem

Preserves Confidentiality

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V. Working with Interpreters

B. Multiple Roles:

Translator of language; Culture Broker, Patient Advocate: Convey expectations, concerns)

Identify the interpreter is as the go-between, not as the person to be blamed, e.g., the interpreter says “The doctor has ordered tests and this is what he says”

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V. Working with Interpreters

C. Translation factors:

Language: How are new words created?

Navajo: Penicillin = “the strong white medicine shot you get for a cold”

Minimize jargon, e.g., “machine to look at your heart” instead of “EKG”.

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V. Working with Interpreters

C. Translation factors:

Nonverbal communication = 60%of all communication

Nodding may indicate politeness, not comprehension.

Bilingual interviewing takes at least twice as long as monolingual interviews!

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V. Working with Interpreters

D. Video vignettes:

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V. Working with Interpreters

E. <u>Clinician Responsibilities:</u>

Learn and use a few phrases of greeting and introduction in the patient's native language. This conveys respect and demonstrates your willingness to learn about their culture.

Tell the patient that the interpreter will translate everything that is said, so they must stop after every few sentences.

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V. Working with Interpreters

E. <u>Clinician Responsibilities:</u>

When speaking or listening, watch the patient, not the interpreter. Add your gestures, etc. while the interpreter is translating your message.

Reinforce verbal interaction with visual aids and materials written in the client's language.

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V. Working with Interpreters

E. <u>Clinician Responsibilities:</u>

Repeat important information more than once.

Always give the reason or purpose for a treatment or prescription.

Make sure the patient understands by having them explain it themselves.

Ask the interpreter to repeat exactly what was said.

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V. Working with Interpreters

E. Clinician Responsibilities:

Personal information may be closely guarded and difficult to obtain.

Patients often request or bring a specific interpreter to the clinic.

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V. Working with Interpreters

E. Clinician Responsibilities:

In some cultures it may not be appropriate to suggest making a will for dying patients or patients with terminal illnesses; this is the cultural equivalent of wishing death on a patient.

Avoid saying “you must ...” Instead teach patients their options and let them decide. E.g., “some people in this situation would ...”

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It is because we are different, that each of us is special.